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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265469	A. Building B. Wing	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levering Regional Health Care Center	1734 Market Street Hannibal, MO 63401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42592 Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of ten sampled residents, remained free from sexual abuse when Dietary Aide A propositioned Resident #1 for sex and attempted to engage in sexual activity. The facility further failed to monitor the whereabouts of Resident #1 and Dietary Aide A directly following discovery of the intent to engage in sexual activity. The facility census was 168. The administrator was notified on 7/17/22 at 3:28 P.M. of the Immediate Jeopardy (IJ), which began on 7/16/22. The IJ was removed on 7/17/22, as confirmed by the surveyor onsite verification. Review of the facility policy, Abuse and Neglect, revised on 9/17/21, showed the following: -Purpose: To outline procedures for reporting and investigating complaints of abuse, neglect, and misuse of funds/property, and to define terms of types of abuse/neglect and misappropriation of funds and property; -Purpose: To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed; -Mistreatment, neglect, or abuse of residents is prohibited by this facility. This includes sexual abuse; -This facility is committed to protection our residents from abuse by anyone, including, but no limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals; -Protection of Residents: Employees of this facility who have been accused of mistreatment will be immediately removed from contact with any residents. 1. Review of Resident #1's PASRR (Pre Admission Screening and Resident Review), for admission to nursing facility dated 3/30/20 showed the following Level I screening: -The resident had been diagnosed with bipolar disorder and received psychiatric treatment in the past two years; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident has a neurocognitive condition secondary to TBI; -The resident required supervision for safety. Review of the resident's face sheet showed the following: -admitted to the facility on [DATE]; -Diagnosis of schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), bipolar disorder (a disorder associate with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and diffuse traumatic brain injury - TBI (brain damage as a result of head trauma); -The resident was under guardianship. Review of the resident's care plan, revised 1/18/22, showed the following: -The resident had impaired cognitive function and impaired thought process related to head injury; -Staff should cue, reorient and supervise as needed. Review of the resident's annual Minimum Data Set (MDS), a federally required assessment instrument completed by facility staff, dated 5/30/22, showed the following: -Responds adequately to simple direct communication only; -Sometimes able to understand others - responds adequately to simple direct communication only; -Moderately impaired cognition; -Limited decision making ability; -No hallucinations, behaviors, or rejections of care; -Supervision by one staff member for transfers, ambulation, and locomotion on and off the unit; -No physical limitations. Review of the facility investigation completed on 7/17/22, showed the following: -Resident #1 said he/she and dietary aide A were talking and that dietary aide A said he/she had money and wanted to know if the resident wanted to go upstairs; -Resident #1 told dietary aide A no because he/she did not want to get caught; -Resident #1 said they then went up the stairs and dietary aide A put his/her genitals in him/her; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Nurse Aide (NA) B came into the room and per the resident it was over; -Upon interview on 7/17/22 by the surveyor, Resident #1 covered his/her face and said 'I lied;' -Resident #1 said his/her pants as well as dietary aide A's pants were down, but NA B came in before anything could happen; During an interview on 7/17/22 at 11:50 A.M. and 3:40 P.M., the resident said the following: -Yesterday dietary aide A told him/her to go up the stairs and they could do it in the stairway; -Doing it meant having sex; -He/She did not want to do it in the stairway because he/she did not want to get caught; -Dietary aide A told the resident that he/she had money if the resident could have sex; -He/She and dietary aide A had their pants down when Nurse Aide (NA) B came into the dining room; -He/She lied to staff when he/she reported he/she and dietary aide A had sex; -There was no completion to the sexual act, because NA B came into the dining room; -Dietary aide A did not give him/her any money; -Dietary aide A let him/her back down the stairs after they were caught by NA B, because dietary aide A felt sorry for him/her; -He/She went back down to the Hang Out (area used by residents for socializing); -Nothing else happened before he/she went back down stairs. Review of the resident's nursing progress notes, dated 7/16/22 at 4:44 P.M., showed the resident was found with staff in possible sexually inappropriate behavior. Head to toe assessment completed on the resident with no new or open areas. No complaints of pain. Resident transported to the emergency room . During an interview on 7/17/22 at 12:20 P.M., NA B said the following: -On 7/16/22, not sure of the time, he/she entered the dining room to get coffee for a resident; -Resident #1 was in the dining room with dietary aide A; -Resident #1 had his/her pants down and underwear partially down; -Dietary aide A was standing behind Resident #1 and Resident #1 was bent over a chair; -Dietary aide A had his/her pants below his/her knees; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Dietary aide A had his/her underwear pulled up; -Dietary aide A asked NA B where he/she came from; -He/She got the coffee for another resident and turned to leave; -He/She turned back around to get Resident #1 to leave with him/her and he/she did not see Resident #1; -He/She was unsure where Resident #1 went; -The NA left the room and did not take the staff member or resident with them; -He/She left and told Certified Nursing Assistant (CNA) E; -He/She along with CNA E reported the incident to Licensed Practical Nurse (LPN) C; -LPN C called the administrator. During an interview on 7/17/22 at 12:41 P.M., CNA E said the following: -On 7/16/22 NA B came to get him/her to report what he/she had seen in the dining room; -He/She went with NA B and reported the incident to the charge nurse LPN C. During an interview on 7/17/22 at 12:53 P.M., LPN C said the following: -On 7/16/22 NA B called him/her to the desk; -NA B reported that he/she saw Resident #1 and dietary aide A in the dining room where Resident #1 was bent forward and appeared to be pulling his/her underwear down; -NA B reported that dietary aide A had his/her pants/shorts down to his/her knees; -Dietary aide A asked NA B what he/she was doing in here/the dining room; -He/She immediately called the administrator; -He/She went to the dining room and did not see Resident #1 or dietary aide A; -He/She called the assistant director of nursing (ADON) to help with the investigation. During an interview on 7/17/22 at 1:24 P.M., Certified Medication Technician (CMT) D said the following: -On 7/16/22 he/she was the team lead for Resident #1; -As soon as the Hangout opened Resident #1 went to the Hangout at 3:09 P.M.; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 reported to him/her that he/she walked up to dietary aide A while he/she was serving food and said they could talk when he/she was on break; -Resident #1 reported to him/her that Dietary Aide A told him/her to meet him/her on second floor; -Resident #1 reported that he/she and dietary aide A walked the stairs together and dietary aide A told the resident he/she wanted to have sex with the resident in the stairwell; -Resident #1 reported he/she and dietary aide A went in the second floor dining room to the first table to the left, dietary aide A bent the resident over the table and they had sex; -NA B walked in on them; -He/She was not sure if the Hangout staff message system alerted when the resident left the Hangout as he/she was passing medication and was not at the desk; -He/She did not notice when Resident #1 returned to the floor; -He/She did not lay eyes on the resident until the ADON came up to assess Resident #1. During an interview on 7/17/22 at 2:30 P.M., the ADON said the following: -Resident #1 told her that dietary aide A took him/her up to the second floor dining room and told the resident that he/she wanted to get a feel; -Resident #1 told her that both parties pulled down their pants and that dietary aide A grabbed the resident at the waist and inserted his/her genitals into the resident; -Another staff member got Resident #1 from the Hangout after the incident so he/she could assess the resident. During an interview on 7/17/22 at 11:30 A.M., the administrator in training said the following: -He was working on 7/16/22 when the ADON called him about 4:38 P.M. and said they needed to start an investigation on a staff member and resident; -He received a phone call from the administrator and directed him to remove dietary aide A from the floor; -He directed a dietary staff member to bring dietary aide A to him and he obtained a statement from dietary aide A. During an interview on 7/17/22, at 11:20 A.M. and 1:00 P.M. the administrator said the following: -On 7/16/22 she received a phone call from LPN C at 4:36 P.M. reporting that NA B went into the second floor dining area and found dietary aide A and Resident #1 involved in possible sexual activity; -She would expect staff not to engage in sexual activity with residents; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-She would expect staff to stay with the resident and remove an alleged perpetrator from the area of residents while an investigation takes place. During an interview on 8/4/22 at 8:51 A.M., the resident's guardian said the following: -The resident did not have a history of seeking relationships with staff members at any facility the resident had been placed in; -He/She was informed that the resident and staff member had been found in an inappropriate situation with outer garments down; -He/She was informed that the resident and staff member had not engaged in actual sexual activity; -He/She felt it was inappropriate for a staff member to interact in an sexual manner with the resident, as the resident has limited cognitive ability and felt like the staff member took advantage of the resident due to that limited cognitive ability. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate and serious jeopardy level J Based on observation, interview and record review completed during the onsite visits, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation. MO00204076